STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey and included the Investigation of Complaints IN00155903 and IN00154731. This visit was done in conjunction with the Investigation of Complaint IN00156113. Complaint IN00155903 - Substantiated. Federal/State deficiencies related to the allegations are cited at F153, F157, F247, F282, and F309. Complaint IN00154731 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey Dates: September 8, 9, 10, 11, 12, 15, 16, & 17, 2014. Facility Number: 00468 Provider Number: 155378 AIM Number: 100290270 Survey Team: Kewanna Gordon RN-TC (September 8, 9, 11, 12, 15, 16, & 17, 2014) Lora Brettnacher RN Census bed type:	F000000	F000000 The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 92 Total: 92 Census payor type: Medicare: 10 Medicaid: 62 Other: 20 Total: 92 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 9/24/14 by Brenda Marshall, RN.			
F000153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of			

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	them upon request and 2 working days advance notice to the facility. Based on interview and record review, the facility failed to provide requested medical records to residents' medical representatives within the required 24 hour time period. This deficient practice affected 2 of 3 residents reviewed for resident rights regarding medical record access (Resident B and Resident F). Findings include: 1. A document entitled, "Authorization for Use and Disclosure of Protected Health Information," received from the Administrator (ADM) on 9/12/14 at 2:17 p.m., indicated Resident B's Power of Attorney requested the residents medical records on 8/19/14. During an interview with the Administrator (ADM) on 9/12/14 at 2:17 p.m., she indicated the facility failed to provide medical records as required to Resident B's legal representative within the required time frame. 2. Resident F's closed record was reviewed on, 9/15/14 at 10:06 A.M. An admission Minimum Data Set assessment tool (MDS), dated, 5/18/14, indicated Resident F had severe cognitive	F000153	F 153- D It is the intent of the facility to provide the Right of Access/ Purchase copies of records. What corrective action will be accomplished for the resident affected. Resident B has deceased and Power of Attorney has received records. Resident F has been discharged. Records provided for Resident F to the Home Health Company upon the verbal request several weeks after discharge. However facility did not keep confirmation receipt. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents have the potential to be effected. Nurses and Department Managers in-serviced on resident and/or legal representative's right to access/purchase copies of records. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. Administrator to be notified if resident and/or legal representative make a verbal request for medical records. Medical Records or designee will make copies of requested information and ensure delivery within 2 working days after request is made. Medical Records or designee will obtain signature of resident or legal representative on Authorization	10/17/2014

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	impairment with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The record indicated Resident B had a legal representative. During a telephone interview on, 9/16/14 at 3:00 p.m., Resident F's legal representative indicated she requested copies of his medical records from the DON (Director of Nursing) a few days after Resident F had been discharged in, June 2014. She indicated the requested medical records had been "thrown away" and therefore could not be provided to her. During an interview on, 9/15/14 at 1:23 p.m., with the DON, Education Coordinator, Administrator, MDS/Care plan Coordinator, and the Director of Nursing (DON) present, the DON indicated she "remembered" Resident B's responsible party had requested from her to have copies of his medical records faxed to his Home Health Agency. The DON indicated she "could not remember" to which Home Health Agency the records were faxed nor had she documented the request for the records. She indicated she "threw away" documentation which indicated the requested medical records were faxed. During this interview the Administrator was asked to provide the facility's policy		for Use and Disclosure of Protected Health Information Form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: Audit tool implemented to track all requests for medical records which includes date request was made, date medical records were provided to resident or legal representative, and whom they were provided to. Medical Records will track requests for Medical Records Audit tool will be reviewed in the Monthly Performance Improvement Committee meeting monthly x6 months and then quarterly until PI Committee determines compliance or further action needed. Completion Date: October 17th, 2014.	

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	on residents' rights of access to medical records. During an interview on, 9/17/14 at 1:20 P.M., with the DON, Education Coordinator, Administrator, MDS/Care plan Coordinator, and DON, and during the Exit Conference on 9/17/14 at 4:00 P.M., the DON indicated documentation was not available which indicated the requested medical records had been provided to the Resident's legal representative or the Home Health Agency. A policy and procedure received from the ADM on 9/12/14 at 2:19 p.m., indicated, "The resident or his or her legal representative has the right... upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays)...." This Federal tag relates to Complaint IN00155903. 3.1-4(b)(2)			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the			

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	resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify a physician of a resident's increased pain for 1 of 3 residents reviewed for physician notification of a change in pain status (Resident B). Findings include:	F000157	F 157 –D It is the practice of this facility to ensure that the Physician, family member, POA/Guardian, are notified when there is an accident involving the resident which has resulted in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental , or	10/17/2014

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	1. A review of Resident B's chart on 9/12/2014 at 11:03 a.m., indicated the resident;s diagnoses included, but were not limited to, right tibia fracture, osteoarthrosis, and dementia without behavioral disturbance. A quarterly Minimum Data Assessment (MDS), dated 7/31/14, indicated Resident B had cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 out of 15. A nurse's note dated, 8/11/14 at 1:00 p.m., indicated, "res (resident) c/o (complaint of) pain/dis (discomfort) upon transfers only..." This noted indicated therapy assessed Resident B due to she had a decline in her ability to tolerate transfers. An untimed Physical Therapy (PT) Evaluation & Plan of Treatment note dated, 8/11/14 indicated, "Patient referred to PT due to new onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced ability to safely ambulate, reduced functional activity tolerance, reduced static and dynamic balance and pain....PMH (Patient Medical History)...R (right) knee pain...Pain at Rest Intensity= 10/10; Frequency/Duration=Constant; Location: RLE (Right Lower Extremity) Pain		psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. It is this facilities practice to also promptly notify the resident and if known the resident's legal representative when there is a change in room or roommate assignments. This facility will also ensure that the resident's records are periodically updated for any/all changes in legal guardianship/POA status, address and phone numbers of said people. What corrective action will be accomplished for the resident affected: Resident B has deceased. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected, therefore the facility will review contact information quarterly with Care Plans to ensure accuracy in information. DON/Designee to review 24 hour report, telephone orders daily for change in conditions and ensure that notifications have been made as appropriate. Condition changes	

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	Description/Type: sharp....Pain With Movement Intensity = 10/10; Frequency/Duration = Constant; location: RLE; Pain Description/Type: sharp." According to this document Resident B's pain was assessed by the patients verbalized pain level. This document further indicated, "Clinical Impressions: Pt (patient) displays severe pain in RLE due to recent dx (diagnosis) of cellulitis.... Assessed stand lift and pt unable to WB (weight bear) through LEs (Lower Extremities) due to pain ...." The record did not indicate the physician was notified of therapy's assessment and/or of Resident B's complaints of severe pain. A nurse's note dated, 8/12/14 at 10:00 a.m., (21 hours after Resident B began exhibiting non verbal and verbal symptoms of severe pain) indicated the physician was notified and an order for an x-ray of her right lower extremity was obtained. A review of a document entitled, "Comprehensive Care Plan," received from the Director of Nursing (DON) on 9/16/14 at 9:00 a.m., indicated , "Notify MD of pain not controlled by current regimen." During an interview with the Administrator (ADM), DON, Assistant		are monitored daily in the Clinical meeting using the White board process. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur. SDC educated nursing staff on signs/symptoms of pain in dementia residents, pain assessments, pain management, and notification of change of condition to appropriate family member and physician. In-services were completed on October 7, 2014 at 6:30a.m., 2:30p.m, 9:30p.m and October 8, 2014 at 2:30p.m . How the corrective actions will be monitored to ensure the deficient practice will not reoccur; what quality assurance program will be put into place.Audit of 24 hour reports and telephone orders will be monitored daily x 7 days, then weekly x3, and then, at random monthly by the UM/ ADON/ DON/SDC and will report findings to the Performance Improvement Committee monthly x 6months and then quarterly until the PI committee determines compliance or further action is required.Completion Date: October 17th, 2014	

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	Director of Nursing, MDS/Care plan Coordinator, Nurse Educator, and Social Service Director present on 9/17/14 at 2:15 p.m., a request was made for documentation a physician was notified of Resident B's severe pain. During the exit conference on 8/17/14 at 4:00 p.m., the Director of Nursing indicated documentation was not available which indicated a physician had been notified during the 21 hours after therapy had assessed Resident B and determined she had severe pain with movement and at rest on 8/11/14 at 1:00 p.m. A policy entitled, "Pain Assessment and Management," received from the DON on 9/15/14 at 3:05 p.m. indicated staff should, "....Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain....Report the following information to the physician or practitioner: Significant changes in the level of the resident's pain....Prolonged, unrelieved pain despite care plan interventions." This Federal tag relates to Complaint IN00155903. 3.1-5(a)(2)			

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F000247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to provide notification of a room change to 1 of 3 residents and/or resident legal representatives reviewed for room change notices (Resident B). Findings include: During an interview with the Social Services Director (SSD) on 9/12/14 at 11:15 a.m., she indicated Resident B's Power of Attorney (POA) had not been informed of the residents move prior to the room change. A document received from the Director of Nursing (DON) on 9/16/14, at 9:00 a.m.,entitled "Care Plan Conference" dated 8/29/14, indicated the POA was "....not notified of room change d/t [due to] being out of town on vacation and wrong # being dialed. Cell phone number not called...."	F000247	F 247 – D It is this facilities practice to ensure that the resident/resident's family /POA receive notice before the resident's room or roommate in the facility is changed. What corrective action will be accomplished for the resident affected? Resident D is deceased. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Audit was performed on all residents with the potential to be affected and all other notifications were in place. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur. A room change notification will be completed by Social Service Director/Designee prior to all room transfers or roommate changes to ensure that notification is completed. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what quality assurance program will be	10/17/2014

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	A policy and procedure received from the Nurse Educator on 9/17/14 at 1:48 p.m., entitled "Change in a Resident's Condition or Status" indicated, "....Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:... There is a need to change the resident's room assignment...." This Federal tag relates to Complaint IN00155903. 3.1-3(v)(2)		put into place: A room transfer audit will be completed by Social Service Director weekly x 4 weeks, monthly x 6mos and then quarterly until PI Committee determines compliance or further action needed. Completion Date: October 17th, 2014	
F000279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services			

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	that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to utilize comprehensive assessments to develop care plans and/or have care plans available for staff utilization. This deficient practice had the potential to affect 4 of 28 residents reviewed for care plans (Residents D, #99, #65, and #114). Findings include: 1. Resident D's record was reviewed on 9/12/14 at 10:45 p.m. Resident D had diagnoses which included, but were not limited to, Alzheimer's disease, muscle weakness, and osteoporosis. Minimum Data Set assessment tools (MDS), dated 12/17/13 and 3/11/14, indicated Resident D had severe cognitive impairment and required extensive physical assistance of two plus staff for transfers from the bed to a chair, wheelchair, and to a standing position. An Activity of Daily Living (ADL) care plan, updated on 3/17/14, indicated Resident D was dependent on staff for all ADLs and transfers. The care plan did not indicate Resident D required the	F000279	F 279 -D It is this facilities practice to ensure each resident has a comprehensive care plan developed with measurable objectives and timetables to meet the resident's needs. The care plan is designed to describe the services that are to be furnished to obtain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. What corrective action will be accomplished for the resident affected? Resident D- Resident care plans and C.N.A. assignment sheets have been reviewed and updated as appropriate. Resident #99- Residents care plans/BMP (behavior management plan) reviewed and revised and C.N.A. assignment sheets updated. Resident #65- Resident Care plans have been reviewed and updated in regards to chronic pain and narcotic usage and C.N.A. assignment sheet updated. Resident #114 was not identifiable in this survey, however staff was able to identify. Care plan has been reviewed and updated and C.N.A. assignment sheet was updated as appropriate. How other resident having the potential to be affected by the same deficient practice will	10/17/2014

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	physical assistance of two staff for transfers. During an interview on 9/12/14 at 1:50 p.m., the Director of Nursing (DON) indicated Resident D's chest was injured during a one person transfer. She indicated, at the time of the injury, Resident D's care did not include specifications which informed staff of the assessed need for the physical assistance of two staff for transfers. During an interview on 9/12/14 at 2:15 p.m., with the DON and Administrator present, the Administrator indicated, at the time Resident D's chest was injured, according to the MDS, Resident D required the physical assistance of two persons for transfers. During an interview on 9/15/14 at 8:25 a.m., CNA (Certified Nursing Assistant) #99 indicated, at the time Resident D was injured, the CNA assignment sheet indicated the resident only required the assistance of one person for transfers. CNA #99 stated, "...There were times I couldn't transfer her by myself. After she was hurt they changed her to a Hoyer (mechanical lift) and a Hoyer requires two people..." During an interview on 09/15/2014 at		be identified and what corrective actions will be taken. All residents have the potential to be affected. Current resident's care plans were reviewed and compared to the C.N.A. assignment sheets for accuracy and implementation by the IDT team (interdisciplinary team) and discrepancies were corrected immediately. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur. A Care Plan audit check list will be utilized to ensure we are reviewing and updating all care plans quarterly and PRN. DON/Designee will review randomly weekly to ensure compliance. How the corrective action will be monitored to ensure the deficient practice will not reoccurr. Care Plan audit check list will be utilized for the next 6 months to ensure we are reviewing and updating all care plans quarterly and PRN. The findings will be reviewed in the Performance Improvement Committee meeting monthly x6 months and then quarterly until PI Committee determines compliance or further action is needed. 5. Completion Date: October 17th, 2014	

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SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

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	10:24 a.m. and at 11:12 a.m., with the Administrator, the Minimum Data Assessment/Care Plan Coordinator Nurse, and the DON present, the MDS/Care plan Coordinator Nurse indicated she developed care plans from the MDS assessments. She indicated Resident D's required extensive assistance of two staff for transfers but the care plan did not reflect the need for the extensive assistance of two persons for transfers. She stated, ..."Yes, if the MDS indicated they were a two person they should have been a two person on the care plan. The care plan is driven from the MDS..." The DON indicated Resident D's care plan did not indicate how many staff were needed to transfer because "her CNAs were allowed to make that judgment." 2. Resident # 99's chart was reviewed on 9/17/14 at 11:36 a.m. The resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15. A quarterly Minimum Data Set (MDS), dated 8/14/14, indicated Resident #99 exhibited behavioral symptoms directed towards others including, but not limited to, physical abuse. A review of a document entitled, "Behavioral Assessment/Psychotropic Medication/Management Plan Initial			

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	Assessment/Quarterly Review," received from the Social Services Director (SSD) on 9/17/14 at 12:16 p.m., indicated the resident had identified behaviors of verbal abuse, physical abuse, resisting care, and socially inappropriate behaviors. The record did not indicate a behavioral care plan with measurable goals or interventions for verbal abuse, physical abuse, and resisting care. During an interview with the SSD on 9/17/2014 at 11:56 a.m., she indicated, the care plans were incomplete and the resident should have had care plans related to verbal abuse, physically abusive behaviors, and resistance to care. 3. A review of Resident #65's chart on 9/17/2014 at 8:42 a.m., indicated diagnosis included, but was not limited to, pain. An annual MDS, dated 7/11/14 indicated Resident #65 had a BIMS of 8 out of 15. Resident #65's medication regimen indicated he received scheduled hydrocodone/acetaminophen 5/325 (narcotic pain medication) three times a day. The record did not indicate a plan of care to address Resident #65's chronic pain and or side effects of the daily use of narcotic pain medication. During an interview on 9/17/2014 9:46 a.m., the MDS/Care Plan Coordinator			

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	indicated Resident #65's record lacked a care plan to address pain. She indicated a care plan should have been initiated related to his pain. A policy titled "Care Planning-Interdisciplinary Team" identified as current by the DON on 9/15/14 at 2:30 p.m., indicated, "...Our facility's Care Planning Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident... A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS)... The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team... Care Area Assessments (CAAs) will be used to help analyze data obtained from the MDS and to develop individualized care plans. CAAs are the link between assessment and care planning...Make decisions about the care plan...Document interventions on the care plan: (1) Include specific interventions, including those that address common causes of multiple issues: and (2) Include recommendations for monitoring and follow-up timeframe..." 3.1-35(a)			

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F000282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure residents were provided with services according to their plan of care in regards to blood sugar monitoring, medication administration, diagnostic lab test, sensory stimulation, and Foley catheter care. This deficient practice had the potential to affect 5 of 28 residents reviewed for services provided as ordered (Residents F, #89, #55, #61, and #8). Findings include: 1. Resident F's closed record was reviewed on 9/15/14 at 10:06 A.M. Resident F had a diagnosis which included, but was not limited to, insulin dependant diabetes. An untimed physician's order, dated 5/16/14, indicated an order for blood sugar accu-checks twice a day at 11:00 a.m. and 4:00 P.M. and for sliding scale insulin coverage. Medication Administration Records	F000282	F 282-E It is the practice of the facility to provide services and/ or arrange services by qualified persons in accordance with each resident's written plan of care. What corrective action will be accomplished for the resident affected: Resident F has been discharged. Resident # 89 has deceased. Resident #55 - Catheter tubing has been secured and draining bag positioned in proper drainage position. Resident #61- Digoxin level was obtained, physician notified and orders were reviewed and clarified. Resident #8 – Remains in the facility, and has had no complications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Audit has been completed to ensure that Activity Interventions are in place as in accordance with the plan of care. Audit has been completed to ensure those residents with a Foley catheter have had their care plans and care guides reviewed and updated as necessary. Audit has been	10/17/2014

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	(MARs) for May and June 2014 were reviewed. The May MAR indicated Resident F did not receive blood sugar monitoring and/or insulin coverage on the following dates: May 17, 18, 19, 20, 22, 23, 26, 27, and 28, 2014 (all 11:00 A.M.). During an interview on 09/15/2014 at 1:23 p.m., the Director of Nursing (DON) indicated documentation was not available which indicated Resident F was provided blood sugar monitoring with insulin coverage as ordered. She indicated most of the nurses who worked at that time no longer work here and were not available to interview. 2a. Observations were made of Resident #89 in bed with his eyes open, blinds closed, lights off, with no television or music playing on the following dates: 9/8/2014: 2:30 p.m. 9/9/2014: 9:44 a.m., 9:59 a.m., and 11:29 a.m. 9/10/14: 9:30 a.m., 10:15 a.m., and 11:00 a.m. 9/11/14: 9:30 a.m., and 10:10 a.m. 9/15/14: 9:25 a.m. Resident #89's record was reviewed on 9/11/14 at 9:47 A.M. Resident #89 had a diagnosis which included, but was not limited to, dementia. The record		completed to ensure those residents receiving blood draws have had their physician orders reconciled to the lab draw list and current results are in the charts as appropriate. Audit has been completed to ensure that blood sugars are being obtained in accordance with the physician's order. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: Staff Development Coordinator (SDC) has educated staff on Catheter Care, including securing catheter competency, review of insulin/ accu-check policy and procedure, sensory stimulation, medication administration , education regarding the reconciliation of monthly orders (i.e. Lab orders), and transcription of physician orders, pain management, pain assessments, physician notification of change of condition/pain, and pain signs/symptoms in residents with dementia. In-services were completed on October 7, 2014 at 6:30a.m., 2:30p.m, 9:30p.m and October 8, 2014 at 2:30p.m and individually as needed, by the SDC/ DON/designee. Care plans will be reviewed upon admission, quarterly and with significant change. Interventions will be reviewed, validated, in place and C.N.A care guides will be validated to ensure continuity in the plan of care. Unit	

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	indicated Resident #89 was a hospice patient for end of life care. An untimed activity note, dated 4/2/14, indicated Resident #89 could not always make his needs known but could respond with yes and no answers. This note indicated Resident #89 had music in his room he enjoyed and staff were to turn it on for him. Big band and classical music were a "major like of his." An activity care plan, dated 9/5/14, indicated Resident #89 had an interest for music sensory programming. Interventions included the resident would be provided with classical and big band music in his room. During an interview on 9/10/14 at 10:28 a.m., Nurse #60 indicated Resident #89 "...Could get up for lunch and that was it." During an interview on 9/16/2014 at 11:59 a.m., the Activity Director indicated Resident #89 did not get out of bed much because of his health condition. She indicated the Certified Nursing Assistants and Activity Staff were supposed to turn his CD player on for him. She indicated they did not have a way to monitor if his music had been turned on for him.		Managers/ ADON/DON/SDC will utilize the White Board process in the daily clinical meeting to ensure physician orders are executed timely, lab orders obtained and appropriate notifications are made. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Accu-check logs will be monitored daily x 7 days, then weekly x3, and then, at random monthly by the UM/ ADON/ DON/SDC. Findings will be reported to the Performance Improvement Committee monthly x 6 months and then quarterly until PI Committee determines compliance or further action is needed. DON/designee will perform daily rounds checklist x7, then weekly x 3 and then at random monthly times to observe for proper catheter tubing and drainage bag placement. Findings will be reported to the performance improvement committee monthly x6 months and then quarterly until PI Committee determines compliance or further action is needed. 1.Completion Date: October --17th, 2014.	

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	2b. During an observation on 9/15/14 at 9:30 a.m., Nurse #60 and the Education Nurse changed a pressure ulcer dressing on Resident #89. Resident #89 was repositioned while care was provided. Resident #89's Foley catheter tubing was pulled taunt and without a method to secure the tubing to prevent it from being pulled out. A care plan, dated 7/31/14, indicated Resident #89 had a Foley Catheter in place. A goal indicated he would not develop complications related to the use of a catheter. Interventions to meet this goal included provide catheter care per the facility policy and prevent tension on urinary meatus from catheter. During an interview on 9/15/14 at 9:50 a.m., Nurse #60 indicated Resident #89's catheter was secured with a "bulb" inflated inside his bladder. She indicated he did have a clip on the catheter to secure the tubing but it currently was not secured. She stated, "He doesn't move around-well, he does, but not enough to pull it. It is anchored with a bulb." During an interview on 9/15/14 at 10:00 a.m., the Nurse Educator indicated the facility utilized Foley catheter clips to avoid tugging on the catheter tubing			

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	during transfers and care delivery to prevent inadvertent catheter removal or tissue injury from dislodging the catheter. 3. Resident #55's record was reviewed on 9/6/14 at 10:18 a.m. Resident #55 had diagnoses which included a history of urinary tract infections and pressure ulcers. During an observation on, 9/5/14 at 9:44 a.m., Resident #55 was observed in bed on her right side. Her catheter tubing was observed stretched taunt over the left side of the bed with the Foley catheter bag lying on the floor. The catheter tubing was not secured to prevent inadvertent catheter removal. During an observation on 9/15/2014 at 9:54 a.m., with Nurse #60 present, Resident #55 was observed in bed with her Foley catheter tubing pulled through a pair of pants that were bunched up at the bottom of her bed. The Foley catheter tubing was not secured to avoid tugging on the catheter during transfer and care delivery to prevent inadvertent catheter removal or tissue injury from dislodging the catheter. A care plan, dated 5/21/14, indicated Resident #55 was dependent on staff for care. A goal included she would have			

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	self care needs anticipated per staff daily. An intervention included Foley catheter care every shift. During an interview on 9/15/14 at 9:54 a.m., Nurse #60 indicated Resident #55's catheter was missing the clip needed to secure the tubing. During an interview on 9/15/14 at 10:00 a.m., the Nurse Educator indicated the facility utilized Foley catheter clips to avoid tugging on the catheter tubing during transfers and care delivery to prevent inadvertent catheter removal or tissue injury from dislodging the catheter. A policy titled "Catheter Care-Indwelling," dated 12/10, and identified as current by the Education Coordinator Nurse on, 9/15/14 at 10:01 a.m., indicated, "...Care of the Drainage Bag: 1. Secure tubing to avoid any unnecessary pulling on tubing..." 4. Resident #61's record was reviewed on, 9/16/14 at 9:31 a.m. Resident #61 had a diagnosis which included, but was not limited to, atrial fibrillation (irregular heart rhythm). Physician recapitulation orders, dated 9/2014, indicated Resident #61 had an order for Digoxin 0.125 mcg			

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	(micrograms) one tablet every other day for the diagnoses of atrial fibrillation and indicated an order for blood work to be obtained every three months to monitor the Digoxin level. The record did not indicate the Digoxin level blood work had been obtained as ordered. During an interview on 9/16/14 at 11:04 a.m., the Director of Nursing (DON) indicated Resident #61 had been prescribed Digoxin for years with an order to monitor her Digoxin level every three months. She indicated the labs had not been obtained since, 11/18/13. She indicated "It must have dropped off." The Digoxin levels due in 2/14, 5/14, and 8/14, had not been obtained. 5. During an observation on 9/16/14 at 9:00 a.m., during medication administration, RN (Registered Nurse) #4 was observed to enter Resident # 8's room to perform her a.m. accucheck. The resident had already began eating her breakfast at this time. RN #4 indicated he would not be able to check her accucheck as ordered because he failed to obtain it before she had eaten. Resident #8's record was reviewed on, 9/16/14 at 11:00 a.m., Resident #8 had a diagnosis which included, but was not limited to, insulin dependant diabetes.			

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	An untimed physician's order dated, 8/24/14 indicated blood sugar monitoring with sliding scale insulin coverage three times daily. This Federal tag relates to Complaint IN00155903. 3.1-35(g)(2)			
F000309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to adequately assess/treat pain resulting in harm to a resident who had an undiagnosed fractured tibia and did not receive pain medication for 21 hours after pain symptoms reported/displayed for 1 of 3 residents reviewed for pain (Resident B). Findings include: 1. A review of Resident B's chart on 9/12/2014 at 11:03 a.m., indicated the resident had diagnoses which included,	F000309	F Tag 309-G It is the intent of the facility to provide the necessary care and services to attain and maintain the highest practicable well-being, in accordance with the comprehensive assessment and plan of care. What corrective action will be accomplished for the resident affected? Resident B is deceased. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents have the potential to be affected. In-services with post-tests were conducted on October 7, 2014 at	10/17/2014

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	but were not limited to, right tibia fracture, osteoarthrosis, and dementia without behavioral disturbance. A quarterly Minimum Data Assessment tool (MDS), dated 7/31/14, indicated Resident B had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 out of 15. At the time of the survey the resident was receiving hospice services and interviews were not obtained due to the resident's health status. A review of a document entitled, "Comprehensive Care Plan," received from the DON (Director of Nursing) on 9/16/14 at 9:00 a.m., indicated Resident B, was "at risk for acute and/or chronic pain r/t (related to) neuropathy, c/o (complaints of) pain in her limbs, OA (osteoarthrosis)" Interventions initiated 4/29/14 included but were not limited to, "Notify MD of pain not controlled by current regimen." A nurse's note, dated 8/6/14 at 11:30 p.m., indicated Resident B had edema, broken blood vessels and reported pain to touch in the right lower extremity along with increased confusion. The record did not indicate the resident was given medication to relieve pain. A nurse's note, dated 8/11/14 at 1:00 p.m., indicated, "res (resident) c/o		6:30a.m., 2:30p.m, 9:30p.m and October 8, 2014 at 2:30p.m. Topics covered include: signs/symptoms of pain in dementia residents, pain assessments, pain management, and notification of change of condition to appropriate family member and physician. Additionally, resident change of condition will be reviewed in the daily clinical meeting using the White board process and during daily walking clinical rounds. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur. SDC educated nursing staff on signs/symptoms of pain in dementia residents, pain assessments, pain management, physician/family notification on October 7, 2014 at 6:30a.m., 2:30p.m, 9:30p.m and October 8, 2014 at 2:30p.m. DON/designee to review 24 hour report, telephone orders , change of condition and will ensure that proper notification has been completed. IDT (interdisciplinary team) to review condition changes, new orders, during the daily clinical meeting utilizing the white board process. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what quality assurance program will be put into place: Audit of 24 hour reports and telephone orders will be monitored daily x 7 days, then	

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	(complains of) pain/dis (discomfort) upon transfers only..." The note indicated the resident was taken for a physical therapy evaluation related to her decreased mobility and difficulty with transfers at this time. The record did not indicate the resident was given pain medication prior to going for the therapy evaluation. An untimed Physical Therapy (PT) Evaluation & Plan of Treatment note, dated 8/11/14 indicated, "....PMH (Patient Medical History)...R (right) knee pain...Pain at Rest Intensity= (is) 10/10 (indicating worst pain); Frequency/Duration=Constant; Location: RLE (Right Lower Extremity) Pain Description/Type: sharp....Pain With Movement Intensity = 10/10; Frequency/Duration = Constant; location: RLE; Pain Description/Type: sharp ...Clinical Impressions: Pt (patient) displays severe pain in RLE due to recent dx (diagnosis) of cellulitis.... Assessed stand lift and pt unable to WB (weight bear) through LEs (Lower Extremities) due to pain ...." The record did not indicate the resident was administered medication to relieve a pain rated at 10 (worst intensity). A nurses note, dated 8/11/14 at 11:06 p.m., indicated, "Resident yelling out		weekly x3, and then, monthly x6 by the DON/designee. Findings will be reported to the to the Performance Improvement Committee monthly x 6 months and then quarterly until PI Committee determines compliance or further action is needed. 5. Completion Date: October 17th, 2014	

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	hitting @ (at) staff when getting up for evening meal took only few bites (sic) assist back to bed by ii (2) and hoyer (sic) no yelling out." The record did not indicate an assessment was completed to determine if the resident yelled due to pain and did not indicate the resident received "as needed" pain medication. Resident B's Medication Administration Record (MAR), dated August 2014, indicated Resident B had routine orders for acetaminophen 650 mg by mouth at 8 a.m. and 8 p.m. and Aspercreme 10% applied topically to her right knee on the day shift and evening shift. The MAR indicated a prn (as needed) order for Tramadol (a narcotic pain reliever) 50 mg (milligrams) by mouth every 6 hours as needed for pain, identified with a start date of 5/16/14. The MAR indicated the resident received Tramadol 50 mg on 8/9/14 at 6:14 p.m. for a pain level of 10 (worst pain). The MAR indicated the resident did not receive Tramadol or any other prn pain medications on 8/10/14 and 8/11/14. The MAR indicated the next dose of Tramadol was not administered until 8/12/14 at 6:52 a.m., 21 hours after the resident's pain level was reported during the physical therapy evaluation as 10 out of 10 on the pain scale, indicating the most severe pain.			

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	A nurse's note, dated 8/12/14 at 10:00 a.m., indicated the physician was notified of the resident's pain and an order was received for an x-ray of the right lower extremity. A nurse's note dated 8/12/14 at 4:00 p.m., indicated Resident B had a fractured tibia. During an interview with the ADM (Administrator), DON, Assistant Director of Nursing, MDS/Care plan Coordinator, Nurse Educator, and Social Service Director present on 9/17/14 at 2:15 p.m., a request was made for documentation which indicated Resident B was administered pain medication during the 21 hour period after she first exhibited signs and symptoms of severe pain. The DON indicated other than Aspercreme and Tylenol (acetaminophen), Resident B had not been administered the stronger as needed narcotic pain medication as ordered. She indicated Resident B only exhibited severe pain with movement and as long as she wasn't moved for care she did not scream out in pain. The DON indicated the resident received care that required movement during the 21 hours she went without effective pain management. A policy entitled, "Pain Assessment and			

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	Management," received from the DON on 9/15/14 at 3:05 p.m. indicated staff should, "....Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain....Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain....Possible Behavioral Signs of Pain...Behavior such as resisting care, irritability, depression, decreased participation in usual activities; Limitations in his or hr level of activity due to the presence of pain;...Report the following information to the physician or practitioner: Significant changes in the level of the resident's pain....Prolonged, unrelieved pain despite care plan interventions." This Federal tag relates to Complaint IN00155903. 3.1-37(a)			
F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the	F000323	F 323 – G It is the practice of	10/17/2014

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	facility failed to ensure a resident was safely transferred with her assessed need of extensive physical assistance of two staff resulting in harm as evidenced by a fractured rib, extensive bruising to the chest area, and a fractured elbow. This deficient practice affected 1 of 5 residents reviewed for accidents (Resident D). Findings include: 1. During a telephone interview on, 9/9/14 at 7:30 a.m., Resident D's son indicated he had concerns regarding injuries to his mother. He indicated during the" last several months" his mother had sustained bruising to her chest and a fractured arm. During a telephone interview on, 9/10/14 at 8:30 a.m., Resident D's daughter indicated she visited her mother daily. She indicated several months ago the facility notified her that they had found a bruise on her mother's chest. She indicated the bruise to her mother's chest was "very large." Resident D's record was reviewed on, 9/12/14 at 10:45 p.m. Resident D had diagnoses which included, but were not limited to, Alzheimer's disease, muscle weakness, and osteoporosis. Minimum Data Set assessment tools		this facility to ensure that the resident environment remains as free of accidents hazards as is possible; and that each resident receives adequate supervision and assistance to prevent accidents. What corrective action will be accomplished for the resident affected: Resident D remains in the facility. Care plans and C.N.A assignment sheet have been reviewed and updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected. Facility will review all care plans as related to ADL needs, and C.N.A assignment sheets updated to ensure assistance is accurately communicated. DON/Designee audited the last 90 days of accidents to ensure that assessments are complete, interventions are care planned and in place at the bedside and that they are communicated on the C.N.A Assignment Sheets. SDC educated nursing staff on incident reporting and transfers on October 7, 2014 at 6:30a.m., 2:30p.m, 9:30p.m and October 8, 2014 at 2:30p.m. Competency evaluations will be conducted on transfers What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: IDT	

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	(MDS) dated, 12/17/13 and 3/11/14, indicated Resident D had severe cognitive impairment and required extensive physical assistance of two plus staff for transfers from the bed to a chair, wheelchair, and to a standing position. Activity of daily living documentation records dated, 3/9/14 through 3/20/14, indicated Resident D was transferred without adequate assistance of two staff fifty-nine times. A nurse's note dated, 3/20/14 at 10:30 p.m., indicated at "approximately" 3:45 p.m., a Certified Nursing Assistant (CNA) noted bruising on Resident D's chest. The resident was not "interviewable" and was not able to "recall the origin of the bruising." The bruising was located on the right breast to mid chest. The bruising measured "11 cm [centimeters] in length and 8 cm in width. Coloring at bruising indicated "several stages of bruising" and the "investigation into possible source of bruising suggested that bruising was likely caused by gait belt..." A signed statement dated, March 20, 2014, indicated, "I Certified Nursing Assistant (CNA) #99 named) transferred [Resident D named] from her bed to her wheelchair by myself... transferring		team reviews events in the daily clinical meeting to determine root cause of the event, examines the scene of the event, both as a part of the investigation and to validate interventions are in place at the bedside, care plan is updated and C.N.A Assignment sheets are reviewed and updated. IDT provides immediate communication to staff at the bedside. Events are evaluated weekly and monthly looking for patterns /trends and are a standing agenda item in the facility monthly Performance Improvement committee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: Events are reviewed weekly and monthly. Trends are identified and action plans developed and reported monthly to Performance Improvement Committee. This will continue indefinitely on a monthly basis. Completion Date: October 17th, 2014.	

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	[Resident D named] is some what kind of difficult. She fights and can't bare weight. I will sometimes ask for assistance to transfer her but not all the time. I feel she should be a two person transfer or a lift to help with less bruising or her feeling unsafe and fighting. When I transfer her by myself I put my arms under hers and lift, when I transfer her with someone else we lift her arm and leg or pants..." A statement signed by CNA #98 and dated, 3/20/14, indicated, "...I transferred [Resident D named]... before and after lunch. The transfers were from bed to wc [wheelchair] and wc to bed. The first transfer from bed to wc I used the gait belt. [Resident D] named got very agitated. She started to grab at my arm and to shout at me. That is not the usual reaction from [Resident D named]. During a transfer I got her into the wc and went to lunch. After lunch I took her back to bed to rest. Because of her prior reaction, I tried to transfer her by putting my arms under hers and lifting her that way she did not resist as much and was not as agitated. I transferred her that way. As an aide, I feel [Resident D named] should really be marked as a 2 person or mechanical lift. She is not comfortable with one person transfers and I feel as though I am causing her discomfort with			

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	or without the gait belt in transfer. She cannot bare weight to assist in the transfer. It agitates and I believe scares her to be transferred..." A nurse's note dated, 3/22/14 at 5:30 a.m., indicated, "Dark purple bruise remains on R [right] breast. Area 9 cm in diameter et [and] painful to touch. Bruise on chest above R breast 12 cm in length et starting to fade..." A nurses note dated, 4/22/14 at 1030 a.m., indicated, "Bruising on R breast et chest remain. Tender to touch..." A nurse's note dated, 3/22/14 at 5:30 p.m., indicated, "Bruising remains to R breast/chest area. Tender to touch...Bruise show 0 (Zero) change from yesterday. Continues dk. [dark] purple-edema, tender to touch..." A nurse's note dated, 3/23/14 at 9:30 a.m., indicated, "Called Dr. to report, hard lump to R upper chest near axillary area. Reported darkening bruising to chest..." This note indicated the physician ordered a chest and right rib x-ray. A radiology report dated, 3/23/14, indicated, "...EXAM Ribs UNI-LAT 2V, Right [Uni-lateral 2 view]. Results:			

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	Healing right fifth posterior rib fracture..." An untimed physician's note dated, 3/24/14, indicated Resident D had a "healing" right fractured rib, bruises to her right "breast into sternum," bruise to her "right axilla yellowish and bruising down to breast," and her skin had "severe bruising..." An untimed physician's note dated, 3/27/14, indicated, "...presents with left hip deformity...lateral left hip area swelling 2 inch x 1 inch hard but mobile...increased pain with movement...rom [range of motion] decreased...pulses present but weak...plan..x-ray..." This note indicated Resident D had a "healing" 5th rib fracture. An untimed physician's note dated, 5/13/14, indicated Resident D was examined due to complaints of right arm and elbow pain. The note indicated Resident D's daughter was present for the examination and indicated Resident D had no history of previous injury to the arm or elbow. The note indicated, "...painful right arm elbow... alert... hurting when right elbow moved...tenderness just below elbow...old bruise over radius...bruising			

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	upper breast better..." A radiology report dated 5/13/14, X-rays of Resident D's right shoulder and right elbow were obtained. The report indicated "...The visualized osseous structures demonstrate a complete subacute fracture involving the right olecranon. No dislocation is seen. Mild diffuse soft tissue swelling is noted..." An untimed physician's note dated, 5/15/14, indicated Resident D had a fractured right ulnar "old 6 week plus," had continued pain in her right arm "especially on rotation of her wrist..." An untimed nurse's note dated, 6/12/14, indicated Resident D had a right rib fracture and a right elbow fracture. The note indicated, "...both happened at the same time... Res [Resident] unable to voice cause. Bruising present current and past..." During an interview on, 9/12/14 at 1:50 p.m., the Director of Nursing (DON) indicated Resident D's chest was injured during a one person transfer. She indicated at the time of the injury Resident D's care plan lacked specifications which informed staff of the assessed need for the assistance of physical assistance of two staff for			

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	transfers. "During an interview on, 9/12/14 at 2:15 p.m., with the DON and Administrator present, the Administrator indicated at the time Resident D's chest was injured, according to the MDS, Resident D did require the physical assistance of two persons for transfers. During an interview on, 9/15/14 at 8:25 a.m., CNA (Certified Nursing Assistant) #99 indicated at the time Resident D was injured the CNA assignment sheet indicated she only required the assistance of one person for transfers. CNA #99 stated, "...There were times I couldn't transfer her by myself. After she was hurt they changed her to a Hoyer and a Hoyer requires two people..." During an interview on, 09/15/2014 at 10:24 a.m. and at 11:12 a.m., with the Administrator, the Minimum Data Assessment/Care Plan Coordinator Nurse, and the DON present, the MDS/Care plan Coordinator Nurse indicated she developed care plan from the MDS assessments. She indicated Resident D's MDS indicated she required extensive assistance of two staff for transfers but her care plan did not reflect the need for the extensive assistance of two persons for transfers. She stated,			

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	..."Yes, if the MDS indicated they were a two person they should have been a two person on the care plan. The care plan is driven from the MDS..." The DON indicated Resident D's care plan did not indicate how many staff were needed to transfer because "her CNAs were allowed to make that judgment." This Federal tag relates to Complaints IN00154731. 3.1-45(a)(2)			
F000428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure pharmacy review recommendations were reported to the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #61). Findings include: Resident #61's record was reviewed on,	F000428	F Tag 428- D It is this facilities practice to have all residents drug regimen reviewed at least monthly by a licensed pharmacist. Once the Pharmacist reviews the regimen, he/she must report any irregularities to the attending physician, and the DON, and the reports must be acted upon. What corrective action will be accomplished for the resident affected? Resident #61	10/17/2014

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	9/16/14 at 9:31 A.M. Resident #61 had diagnoses which included, but were not limited to, insulin dependent diabetes, dementia, and hypertension. Pharmacy review notes dated, 5/14/14 and 7/18/14, indicated the pharmacist had reviewed Resident #61's medication regimen and recommendations indicated Resident #61 was receiving Glipizide, Novolin R sliding scale twice a day with levemir 77 units every evening. Her fasting glucose was within normal limits with her 4 p.m. glucose elevated. "Suggest discontinue of sliding scale and adding a routine dose of Novolog 5 units with lunch." The record lacked documentation the physician had been notified of the pharmacist's recommendations. During an interview on, 9/16/2014 at 3:15 p.m., with the Administrator present, the Director of Nursing indicated the pharmacy recommendations for Resident #61 dated, 5/14 and 7/18/14, had not been reported to the physician. 3.1-25		Pharmacy recommendations have been reviewed and followed up on. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents have the potential to be affected. DON/Designee will review all pharmacy recommendations and ensure all are followed up on. All pharmacy recommendations are followed up on monthly. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur. Audit to be completed by DON/Designee to review all Pharmacy Recommendations from the last 60 days to ensure Physician has followed up and documentation is present in chart. Pharmacy report with recommendations will be reviewed by DON/Designee monthly. Recommendations will be given to Medical Director/Physician within 72 hours of receipt of pharmacy report and recommendation follow up will occur weekly by the DON/ Designee with the attending physician. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what quality assurance program will be put into place: Weekly audit of outstanding recommendations to be completed by DON/Designee for	

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			follow up with the attending physician. Performance Improvement committee will review audit monthly x 6mos, and then quarterly until PI committee determines compliance or further action needed. Completion Date: October 17th, 2014	